Asante-Tannor v Chang
2016 NY Slip Op 31832(U)
September 26, 2016
Supreme Court, New York County
Docket Number: 805015-2014
Judge: George J. Silver
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 10

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KAWASI ASAŃTE-TANNOR,

Plaintiff,

Index No. 805015-2014

-against-

DECISION/ORDER

Motion Sequence 003

BETTY CHIA-WEN CHANG, M.D., NEW YORK PRESBYTERIAN HOSPITAL/COLUMBIA UNIVERSITY MEDICAL CENTER, BARRY M. ROSENTHAL, M.D. and WINTHROP UNIVERSITY HOSPITAL,

Defendants.

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HON. GEORGE J. SILVER, J.S.C.

Recitation, as required by CPLR § 2219 [a], of the papers considered in the review of this motion:

Papers	Numbered
Notice of Motion, Attorney's Affirmation, Memorandum of Law & Collective Exhibits Annexed	1, 2, 3, 4
Affirmation in Opposition & Collective Exhibits Annexed	5, 6
Reply Affirmation	7

In this action for medical malpractice, lack of informed consent and negligent hiring, defendants Betty Chia-Wen Chang, M.D. and the New York and Presbyterian Hospital s/h/a New York-Presbyterian /Hospital Columbia University Medical Center (Presbyterian) (collectively defendants) move pursuant to CPLR § 3212 for an order granting them summary judgment dismissing plaintiff Kawasi Asante-Tannor's (plaintiff) complaint. Plaintiff opposes only the portion of the motion seeking summary dismissal of his medical malpractice claim. Accordingly, defendants are entitled to summary dismissal of the lack of informed consent and negligent hiring causes of action.

According to the medical records, plaintiff, then 66 years old, presented to Presbyterian's emergency department at 11:40 a.m. on February 10, 2012 with complaints of a headache and high blood pressure. Plaintiff's headache is described as throbbing with a pain level of 10 out of 10. At 12:20 p.m. plaintiff's blood pressure was 240/125 sitting. According to the medical records, plaintiff indicated to the Presbyterian staff that he had stopped taking his blood pressure

medication a year prior because it was causing him to urinate too much. At 1:02 p.m. the blood pressure medication Clonidine HCL was administered to plaintiff. A repeat blood pressure was to be taken within one hour after the blood pressure medication was administered. An electrocardiogram was administered at 1:27 p.m. which showed "sinus bradycardia, possible left atrial enlargement, left ventricular hypertrophy and T wave abnormality" indicating possible inferolateral ischemia. Plaintiff was examined by a resident at 2:00 p.m. Plaintiff was in no acute distress. The examination revealed a left eye leftward gaze and nonreactive pupil. The neurological examination was within normal limits and plaintiff was oriented to person, place and time. At 2:03 p.m. plaintiff's blood pressure 194/93 supine and plaintiff was given a second dose of Clonidine at 2:53 p.m. At 4:31 p.m. plaintiff's blood pressure was 150/79. A discharge plan was devised whereby plaintiff would be discharged on an anti-hypertension medication, but not a diuretic. Specifically, the discharge plan was to start plaintiff on Labetalol once per day. An appointment was scheduled for plaintiff with a primary care physician on February 15, 2012. The discharge order was placed at 7:55 p.m. At that time plaintiff's blood pressure had risen to 170/92 supine. Plaintiff was discharged from the emergency department at 9:02 p.m. On February 13, 2012 at 6:33 a.m. plaintiff presented to the emergency department at co-defendant Winthrop University Hospital (Winthrop) with a chief complaint of diarrhea. Plaintiff's blood pressure was 232/126. Plaintiff was given Labetalol HCL 20 mg IV at 9:25 a.m. and Labetalol 100 mg oral at 9:25 a.m. Plaintiff was discharged from Winthrop's emergency department but at 11:08 a.m., while he was still at Winthrop, plaintiff suffered a stroke that resulted in paralysis to the left side of plaintiff's body.

In support of the motion defendants submit an affirmation from Dr. Thomas Kwiatkowki (Kwiatkowki), a physician licensed to practice in New York and board certified in Internal Medicine and Emergency Medicine. According to Kwiatkowki, a patient is experiencing a hypertension urgency when he or she is experiencing high blood pressure but is not exhibiting any clinical signs or symptoms as a result of the high blood pressure. A patient is experiencing a hypertension emergency, on the other hand, when the patient has high blood pressure and is exhibiting evidence of acute end organ damage such as pulmonary edema, hypertensive encephalopathy, chest pain or aortic dissection. Kwiatkowki contends that plaintiff did not present to Presbyterian with any evidence of end organ damage and that it was appropriate for defendants tp treat plaintiff's presentation as a hypertensive urgency and not as a hypertension emergency which requires more aggressive treatment, including admission to the hospital.

Specifically, Kwiatkowki contends that defendants appropriately acknowledged that plaintiff's high blood pressure needed to be lowered when plaintiff presented to Presbyterian with a blood pressure of 240/125. Kwiatkowki further opines that plaintiff's blood pressure at the time of discharge, 170/92, although high, was lowered to a degree that was within as acceptable and appropriate range given plaintiff's history of untreated hypertension for one year. With respect to plaintiff's throbbing headache, Kwiatkowki contends that there is no clinical indication in the record of a neurological deficit which warranted a CT scan of plaintiff's brain, other than plaintiff's left eye leftward gaze nonreactive pupil. Kwiatkowki further claims that the left eye leftward gaze nonreactive pupil was reported by plaintiff to be a chronic condition secondary to trauma and that defendants were under no obligation to conduct any further examination regarding the left eye condition. With respect to plaintiff's abnormal EKG results,

Kwiatkowki opines that the results demonstrated secondary changes due to plaintiff's long standing hypertension and that defendant were again under no obligation to conduct any further testing as a result of the EKG. Kwiatkowki thus concludes that defendants acted in accord with good and accepted medical practice by not admitting plaintiff and not performing any additional clinical examinations, radiographic examinations or serial blood pressure monitoring. Kwiatkowki also concludes that defendants' discharge plan was entirely appropriate and that plaintiff was given appropriate follow-up instruction including an appointment with a primary care physician. According to Kwiatkowki, plaintiff was discharged with an appropriate anti-hypertensive medication in an appropriate dosage and it was appropriate to reduce the dosage from twice per day to once per day given plaintiff's reported noncompliance with blood pressure medication during the prior year. Kwiatkowki claims that the fact that plaintiff blood pressure had risen from 150/79 to 170/92 at discharge does not affect his opinion that it was appropriate to discharge plaintiff. Finally, Kwiatkowki contends that the decision to discharge plaintiff on February 10, 2012 was not a substantial factor in causing the stroke that plaintiff suffered on February 13, 2012.

In opposition, plaintiff submits a redacted notarized affirmation[1] from a physician board certified in emergency medicine and licensed to practice medicine in the State of Maryland. Plaintiff's expert contends that when he presented to Presbyterian's emergency department on February 10, 2012 plaintiff was experiencing a hypertensive emergency. Plaintiff's expert defines a hypertensive emergency as a patient exhibiting blood pressure of 180/110 or greater in which the uncontrolled blood pressure leads to progressive or impending end organ dysfunction. According to plaintiff's expert, hypertensive emergency patients require admission to the hospital. More specifically, plaintiff's expert contends that there are two reasons why plaintiff should have been admitted to the hospital upon his presentation to the emergency department. First, although plaintiff was given a prescription for Labetalol, plaintiff's blood pressure was trending up at the time of discharge and had increased from 150/79 to 170/92. According to plaintiff's expert, plaintiff needed to be monitored on Labetalol to see if the medication would control his blood pressure the way the Clonidine did. Admission for 24 to 48 hours was the standard of care, according to plaintiff's expert, and would have allowed for such monitoring. Secondly, the ECG performed on plaintiff showed a T-wave inversion in the inferior and lateral leads and demonstrated an irregular lack of blood flow. According to plaintiff's expert, a variety of clinical syndromes can cause T-wave inversions, ranging from life-threatening events such as acute coronary ischemia, pulmonary embolism and central nervous system injury. Plaintiff's expert contends that plaintiff's abnormal ECG required admission and a further work-up to determine if the ECG represented an acute event. Plaintiff's expert argues that without a prior ECG to compare with the one taken on February 10, 2012, it cannot be said that the ECG results demonstrated secondary changes due to plaintiff's long standing hypertension, as defendants' expert argues, and opines that the abnormal ECG results alone required plaintiff to be admitted to the hospital.

Plaintiff's expert further opines that the standard of care for a patient such as plaintiff who presents in a hypertensive crisis is to perform initial laboratory studies, including a

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[1] An unredacted affirmation was submitted by plaintiff for in camera review.

urinalysis with sediment examination, a stat chemistry exam and an electrocardiogram in order to evaluate for organ dysfunction resulting from the severe hypertension. Bloodwork in the form of a complete blood count, metabolic profile, Creatine Phosphokinase (CPK), CPK-MB and checking of troponin levels also should have been performed. Plaintiff's expert also contends that a urine sample should have been taken by defendants and argues that three days later urine analysis taken at Winthrop showed protein in plaintiff's urine and chemistry showed increased creatinine level, both of which are evidence of renal dysfunction. According to plaintiff's expert, when the kidneys are damaged due to hypertension protein leaks into the urine. Had defendants administered a urinalysis and bloodwork of plaintiff when he presented the results would have similarly shown proteinuria and increased levels of creatinine, indicative of kidney damage due to hypertension. Plaintiff's expert claims that admission to the hospital was necessary not only to regain control of plaintiff's blood pressure but to address his heart and kidney function so as to avoid further injury to his organs as well as serious injury such as stroke.

With respect to the discharge plan, plaintiff expert's contends that even in the absence of end organ failure, plaintiff's severely elevated blood pressure levels required that plaintiff be directed for follow-up monitoring within 24 hours and defendants' failure to direct plaintiff to do so was a departure from accepted standards of medical care. Finally, plaintiff's expert opines that defendants failure to monitor plaintiff on Labetalol for at least 24 hours and to otherwise evaluate and treat him on an inpatient basis caused plaintiff's blood pressure to return almost immediately to severely high levels which continued to place strain on plaintiff's blood vessels and was a proximate cause of plaintiff's stroke on February 13, 2012.

In an action premised upon medical malpractice, a defendant doctor establishes *prima facie* entitlement to summary judgment when he/she establishes that in treating the plaintiff there was no departure from good and accepted medical practice or that any departure was not the proximate cause of the injuries alleged (*Thurston v Interfaith Med. Ctr.*, 66 AD3d 999, 1001 [2d 2009]; *Myers v Ferrara*, 56 AD3d 78, 83 [2d 2008]; *Germaine v Yu*, 49 AD3d 685 [2d Dept 2008]; *Rebozo v Wilen*, 41 AD3d 457, 458 [2d Dept 2007]; *Williams v Sahay*, 12 AD3d 366, 368 [2d Dept 2004]).

With respect to opinion evidence, it is well settled that expert testimony must be based on facts in the record or personally known to the witness, and that an expert cannot reach a conclusion by assuming material facts not supported by record evidence (*Cassano v Hagstrom*, 5 NY2d 643, 646, 159 NE2d 348, 187 NYS2d 1 [1959]; *Gomez v New York City Hous. Auth.*, 217 AD2d 110, 117 [1st Dept 1995]; *Matter of Aetna Cas. & Sur. Co. v Barile*, 86 AD2d 362, 364-365 [1st Dept 1982]). Thus, a defendant in a medical malpractice action who, in support of a motion for summary judgment, submits conclusory medical affidavits or affirmations, fails to establish *prima facie* entitlement to summary judgment (*Winegrad v New York Univ. Med. Ctr.*, 64 NY2d 851, 853, 476 NE2d 642, 487 NYS2d 316 [1985]; *Cregan v Sachs*, 65 AD3d 101, 108 [1st Dept 2009]; *Wasserman v Carella*, 307 AD2d 225, 226 [1st Dept 2003]). Further, medical expert affidavits or affirmations, submitted by a defendant, which fail to address the essential factual allegations in the plaintiff's complaint or bill of particulars fail to establish prima facie entitlement to summary judgment as a matter of law (*Cregan*, 65 AD3d at 108; *Wasserman* 307 AD2d at 226).

Once the defendant meets her burden of establishing prima facie entitlement to summary

judgment, it is incumbent on the plaintiff, if summary judgment is to be averted, to rebut the defendant's prima facie showing (*Alvarez v Prospect Hosp.*, 68 NY2d 320, 324, 501 NE2d 572, 508 NYS2d 923 [1986]). The plaintiff must rebut defendant's prima facie showing without "[g]eneral allegations of medical malpractice, merely conclusory and unsupported by competent evidence" (*id.* at 325). Specifically, to avert summary judgment, the plaintiff must demonstrate that the defendant did in fact commit malpractice and that the malpractice was the proximate cause of the plaintiff's injuries (*Coronel v New York City Health and Hosp. Corp.*, 47 AD3d 456 [1st Dept 2008]; (*Koeppel v Park*, 228 AD2d 288, 289 [1st Dept 1996]). In order to meet the required burden, the plaintiff must submit an affidavit from a medical doctor attesting that the defendant departed from accepted medical practice and that the departure was the proximate cause of the injuries alleged (*Thurston* 66 AD3d at 1001; *Myers* 56 AD3d at 84; *Rebozo* 41 AD3d at 458).

Defendants' submission establishes prima facie that defendants did not deviate from good and accepted medical practice in their treatment of plaintiff and that their treatment was not the proximate cause of plaintiff's alleged injuries. In opposition, plaintiff fails to raise a triable issue of fact. Even accepting as true plaintiff's expert's contention that plaintiff was experiencing end organ failure of his heart and kidneys and that plaintiff was therefore experiencing a hypertension emergency that required his admission to the hospital, plaintiff's submission does not raise a triable issue of fact on the issue of causation. While it is true that a plaintiff need only offer sufficient evidence from which a reasonable person might conclude that it was more probable than not that the defendant's deviation from accepted medical standards was a substantial factor in causing the injury and that a plaintiff's evidence of proximate cause may be found legally sufficient even if the plaintiff's expert is unable to quantify the extent to which the defendant's act or omission decreased the plaintiff's chance of a better outcome or increased the injury (*Goldberg v Horowitz*, 73 AD3d 691 [2d Dept 2010]), plaintiff's submission does not satisfy this standard. Plaintiff's expert merely opines that had plaintiff been admitted to the hospital defendants would have been able to monitor plaintiff's blood pressure while he was on Labetalol. The expert does not offer any opinion as to whether defendants would have been able to control plaintiff's blood pressure upon his admission and thus would have been able to prevent or reduce the severity of plaintiff's stroke. Therefore, plaintiff's expert's conclusion that defendants' alleged malpractice proximately caused plaintiff's stroke is speculative and does not establish "the requisite nexus between the malpractice allegedly committed and the harm suffered" (*Dallas-Stephenson v Wasiman*, 39 AD3d 303, 307 [1st Dept 2007]). Accordingly, it is hereby

ORDERED that defendants Betty Chia-Wen Chang, M.D. and the New York and Presbyterian Hospital s/h/a New York-Presbyterian /Hospital Columbia University Medical Center's motion for summary judgment is granted and the complaint against them is dismissed; and it is further

ORDERED that the Clerk is directed to enter judgment accordingly; and it is further

ORDERED that the action is severed and continued against the remaining defendants and that the caption should be amended to reflect the dismissal of the complaint against Betty Chia-

Wen Chang, M.D. and the New York and Presbyterian Hospital s/h/a New York-Presbyterian /Hospital Columbia University Medical Center; and it is further

ORDERED that the remaining parties are to appear for a status conference on November 2, 2016 at 2:15 p.m. in Part 10, room 422 of the courthouse located at 60 Centre Street, New York, New York 10007; and it is further

ORDERED that movants are to serve a copy of this order, with notice of entry, upon all parties within 20 days of entry.

George J. Silver, J.S.C.

Dated: 9/26/16
New York County

GEORGE J. SILVER